S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

Individual and Family Support/Respite - Request for Payment

SECTION A: PAYEE INFORMATION

Payee: _____

Address: _____

_____

SECTION B: PAYMENT INFORMATION

Payment Month: _____

Payment Amount: $_____

Check one:

_____One-Time Payment

_____Monthly Payment (PO Required)

Purchase Order Number: _____

Vendor Number: _____

SECTION C: APPLICANT INFORMATION

Applicant's Name: _____

Applicant's SS#: _____

Description of Service: _____

Co-Pay Amount: _____

SECTION D: AUTHORIZATION

I hereby certify that all information is true and applicable.

_____ _____

Signature of Executive Director/Designee Date